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October 19, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic pain management program (CPMP) 10 sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx. The patient was involved in a motor vehicle accident (MVA) in which his vehicle rolled over.

On xxxxxxx, the patient underwent a magnetic resonance imaging (MRI) of the lumbar spine at East Side Imaging. At L3-L4, there was a broad-based posterior disc bulge measuring 3 mm without stenosis with subtle disc space narrowing. At L4-L5, there was posterior subligamentous disc herniation measuring 5-6 mm creating mild-to-moderate central spinal canal stenosis. At L5-S1, there was a 2 mm disc bulge without stenosis.

An MRI of the left shoulder obtained on the same date demonstrated an equivocal tear of the posterior labrum, minimal edema within and adjacent to the left acromioclavicular (AC) joint suggesting grade 1 separation, 8-10 mm subchondral cysts involving posterior aspects of the glenoid fossa most likely reflecting an incidental finding.

A right shoulder MRI showed edema within and adjacent to the right AC joint suggesting grade 1 separation and/or posttraumatic osteolysis. A lobulated septated cystic lesion was measuring approximately 12 x 14 mm adjacent to the anterior superior glenoid labrum, although this was a common location for paralabral cyst associated with labral tears. This most likely reflected an incidental ganglion cyst.

On January 21, 2014, the patient presented for low back pain and neck pain. It was noted following the MVA, the patient was taken via xxxxxx. He had diagnostic studies and was referred to his treating doctor. The patient had been referred to for lumbar and cervical injury, a maxillofacial doctor for injuries to his right eye orbit fracture and nose fracture and for right shoulder labrum tear. The low back pain was 9/10. Examination of the cervical spine showed restricted range of motion (ROM), tenderness to palpation over the C4 through C7 areas, pain radiating to the bilateral trapezius. Examination of the lumbar spine showed decreased ROM, tenderness to palpation over the L4 through S1 and bilateral paraspinous muscles, pain radiating through the left calf, foot, gluteus, thigh and toes. Kemp's test was positive on both sides of the lumbar region. The diagnoses were lumbar radiculitis, lumbar HNP, closed cervical vertebral fracture without spinal cord injury. recommended 12 visits of therapy to the neck and back.

From January 29, 2014, through March 12, 2014, the patient underwent extensive therapy at the consisting of neck stretches and lumbar stretches.

evaluated the patient from April 3, 2014, through November 13, 2014, for low back pain radiating to the left lower extremity with a pain level of 7-9/10. Examination showed poor heel and toe walk on the left. There was a sensory deficit in the left L5-S1 dermatome and a positive straight leg raising (SLR) on the left. He diagnosed lumbar herniated nucleus pulposus (HNP), lumbar radiculopathy and lumbar strain.

evaluated the patient at on March 11, 2014, for worsening symptoms. The patient reported Tylenol was not helping him. On examination, the patient was in moderate distress. Cervical ROM was decreased. Palpation was positive for tenderness in the spinous and paraspinous areas bilaterally. Straight leg raising (SLR) test was positive on the left, lumbar ROM was decreased to all planes moderately, and palpation was positive for pain at the L3 through L5 spinous processes and paraspinous area. Bilateral shoulder examination showed decreased ROM in all planes with pain during ROM testing. The diagnoses were cervical fracture, L4-L5 disc herniation, bilateral shoulder pain, nasal fracture and orbital fracture. Etodolac, Ultram and Elavil were prescribed. The patient was placed on light duty and referred to pain management.

evaluated the patient on May 12, 2014, for neck and back pain. He assessed cervical vertebral fracture, lumbar herniated disc and lumbar sprain/strain.

On June 18, 2014, the patient underwent electrodiagnostic studies there was nerve conduction and electromyography (EMG) evidence consistent with a left L5-S1 radiculopathy with both acute and chronic denervation changes, left median neuropathy at the wrist, consistent with a clinical

diagnosis of carpal tunnel syndrome (CTS) on the left.

On June 27, 2014, an MRI of the cervical spine showed uncovertebral joint spurring and facet joint hypertrophy mildly narrowing the right C4-C5 neural foramen and impinging the exiting right C5 nerve root, 1-2 mm diffuse annular disc bulges and/or posterior osteophyte spurring at the C3-C4, C4-C5, C5-C6 and C6-C7 levels, mild desiccation at the C2-C3 through C6-C7 disc space and reversal of the normal lordosis.

evaluated the patient on December 9, 2014, and noted the patient had been treated with nonsteroidal anti-inflammatory drugs (NSAIDs), physical therapy (PT) and home exercise program (HEP) without improvement. prescribed cyclobenzaprine, methylprednisolone and tramadol HCl and gave referral to pain management.

performed a designated doctor evaluation (DDE) on December 23, 2014, and assessed maximum medical improvement (MMI) with whole person impairment (WPI) rating of 10%.

On January 28, 2015, the patient underwent a lumbar ESI at L4-L5.

In a follow-up on February 27, 2015, noted the patient had 80 to 90% pain relief with the ESI; however, the pain had started to return. A repeat ESI was discussed.

In a DDE on March 31, 2015, stated the patient was not at pending therapeutic ESIs and post-injection therapy. The patient should be allowed to continue therapy for the cervical spine and right shoulder.

On May 6, 2015, the patient underwent a lumbar ESI.

pain management, evaluated the patient on May 19, 2015. She noted following the MVA, the patient had been diagnosed with a broken nose, orbit blowout, transverse process fracture of the cervical spine as well as shoulder and lumbar injury. The patient was in a cervical collar for four months. Currently, the patient complained of mostly neck pain that was constant and severe. The back pain radiated to the lower extremities with numbness and tingling. prescribed Norco, Lyrica and tizanidine and ordered EMG/NCV study.

Electrodiagnostic studies performed by on June 13, 2015, showed electrophysiological evidence of moderate-to-severe right median nerve lesion at the wrist and forearm compatible with moderate-to-severe right CTS and pronator syndrome. There was also electrophysiological evidence of a right upper trunk brachial plexopathy. The study was interpreted by.

On June 23, 2015, referred the patient to for evaluation of the CTS and brachial plexopathy. The patient was referred to a spine surgeon for further treatment of his back. Lyrica dose was increased while Norco and Zanaflex were continued.

On July 9, 2015, reviewed the electrodiagnostic study and recommended a right CTR, right ulnar nerve release, right median nerve release at the elbow.

On July 16, 2015, the patient underwent a. On the BDI, the patient score 8 (minimal range of assessment). On the BAI, the patient scored 12 (mild range of assessment). On the Screener and Opioid Assessment for Patients in Pain-Revised (SOAPP-R) the patient scored an 18, while on the Fear Avoidance Beliefs Questionnaire (FABQ), the patient scored 14 on the work scale and 3 on the activity scale. The treatment recommendations included 10 trial sessions of a behavioral multidisciplinary chronic pain management program (CPMP).

On July 22, 2015, requested approval of a therapeutic lumbar ESI.

On July 28, 2015, recommended a cervical ESI at C6-C7 for cervical radiculopathy and another ESI for the lumbar radiculopathy. Refills were provided for Lyrica, tizanidine and Norco.

In a functional capacity evaluation (FCE) dated July 28, 2015, the patient demonstrated the ability to perform within the light Physical Demand Category based on the definitions developed by the US Department of Labor and outlined in the Dictionary of Occupational Titles.

Per utilization review dated August 7, 2015, the request for 10 sessions of CPMP was denied with the following rationale: *"The most recent evaluation dated July 22, 2015, indicated that a previous ESI provided adequate pain relief and functional improvement. A subsequent ESI was also being requested. Moreover, a comprehensive clinical evaluation to show physical deficits that need to be addressed with the Chronic Pain Management Program was not provided. Physical Treatment goals were not elaborated on. A multidisciplinary treatment is not warranted for a patient with primarily psychological deficits. There was also no indication that the patient has motivation to change, and is willing to change their medication regimen."*

On August 19, 2015, appealed the denial of the CPMP. She stated during the interview, the patient had reported a strong desire to go back to work but was also unsure if he could possibly do the same work as he did not know if he was physically and mentally able. Because his monetary compensation is coming to an end quite soon, the CPMP addressing vocational rehabilitation would greatly help this patient.

Per utilization review dated September 3, 2015, the appeal for 10 sessions of CPMP was non-certified. Rationale: *"Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not certified due to success with lower levels of care and lack of demonstration of motivation to change."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the medical records he is treated with minimal medications and one of the

main goals is to reduce or discontinue medications. In addition, ODG states "Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement" which is not the case here. He had significant improvement with ESI and is maintained on minimal medications.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES